DEPARTMENT OF HEALTH AND HUMAN SERVICES



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PRINTED: 10/25/2007 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			•	OMB NO.	<u>0938-0391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		09G127	B. WIN			10/12	/2007
NAME OF P	ROVIDER OR SUPPLIER	090121		41	EET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE VASHINGTON, DC 20019	10/12	12001
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
w 000	INITIAL COMMEN	·	W	000			
	October 10, 2007 to random sample of	rvey was conducted from through October 12, 2007. A two clients was selected from of four male clients with disabilities.					
W 104	survey process. T based on observal two day program, i consultants and re the habilitation and	ompleted using the fundamental the findings of this survey were stone at the group home and interview with day program esidential staff, and a review of diadministrative records.	w	104			,
	The governing boo budget, and opera	dy must exercise general policy, iting direction over the facility.			The Director of Health Services provided all medication nurses a TME's addition training on accudocumentation of medication administration. Training was con	nd rate	10/30/07- Ongoing
	Based on observa	is not met as evidenced by: ation, staff interview and record is Governing Body failed to operating direction over the ad in the following:			on 10/30/2007. The delegating review the MAR at least once we monitor documentation. The Di Health Services will conduct a re QA of the client medical adminitive records and provided the follow-	eekly rector of outine stration	
	effective system for Trained Medication accurate document administration as	Body failed to have an or nursing personnel to monitor on Employees to ensure ntation of medication detailed in the agencies nursing ures. [See W189 and W365]			necessary to ensure accurate documentation of medication administration and nursing compatith established protocols.	•	
	nursing staff followaccordance with the procedures. [See and W382]	Body failed to ensure that wed agency nursing protocol in the agency's policy and W331, W322, W371, W381		400			
W 120		RVICES PROVIDED WITH		120			CAN DATE!

Any deficiency statement ending with an asterist (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT AND FLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING		COMPLETED		
		09G127	B. Wii			10/1	2/2007
NAME OF P	ROVIDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE VASHINGTON, DC 20019		
(X4) ID PRÉFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 120	Continued From particles of Cut's DE SOURCE The facility must at meet the needs of This STANDARD Based observation review, the facility program met their the sample. (Client The findings included their day program their day program.)  1. Direct care stated observed repositioning protects their day program. In the facility failed their day program. Interview with the facilities described their day for the facility of the facility failed their day program. Interview with the facility of the fa	age 1 ES ssure that outside services each client. is not met as evidenced by: n, staff interview and record failed to ensure that the day needs of two of the two clients in nt #1 and #2)	W	120	1-2. The QMRP has provided day program staff on the repos protocol for Client # 1. Training verification has been placed in record. QMRP has also provid program with a repositioning district which will be returned to the reprogram on a weekly basis and Client #1 and #2 record.  The day program has been provided a copy current Health Manager Plan which specifically details integrity and repositioning profit.	itioning ng client #1 ed the day lata sheet esidential I filed in  vided with ment Care skin	11/01/2007 – Ongoing
	irritation and breathe QMRP reveal this protocol to the training to the day procedure was be program.  Review of the Ind	kdown. Further interview with ed that she had not presented e day program or provided y program to ensure that this eing implemented at the day lividual Program Plan on					
	October 11, 2007	ividual Program Plan on at 2:00 PM revealed that Client to be "repositioned every two					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVINDER:  A, BUILDING (X3) DATE SURVINDER:						
*		09G127	B. WIN	۱G	<u> </u>	10/1	2/2007
MAME OF P	ROVIDER OR SUPPLIER		•	4	REET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE VASHINGTON, DC 20019	<del></del>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 120	hours when he is a delicate skin in his also included a rep to be record when it Review of the record repositioning data.  2. On October 10 a was observed throughout the Client #2. The Clie ambulate with his was to sit in a regular character of the control of the purand breakdown. For evealed that the character of the day program day program to ensibeing implemented. Review of the Indiv October 11, 2007 a #1 was to "stand for hours when he is a delicate skin in his referred to a repositioning the repositioning. There day program Plan of Calany skin integrity correpositioning. There day program had be delicated to the refront the day program of Calany skin integrity correpositioning. There day program had be delicated to the refront the day program of Calany skin integrity correpositioning. There day program had be delicated to the refront the day program had be delicated to the refront the day program of Calany skin integrity correpositioning. There day program had be delicated to the refront the day program had be delicated to the refront the day program had be delicated to the refront the day program had be delicated to the refront the day program had be delicated to the refront the day program had be delicated to the refront the day program had be delicated to the refront the day program had be delicated to the refront the day program had be delicated to the refront the re	wake to relief stress on the sacral area." The protocol ositioning check sheet for data implementing this protocol. It does not evidence any from Client #1's day program.  and 11, 2007 direct care staff lighout the survey repositioning int was allowed to stand and to valker, to sit on the couch and hair during his meals.  Irrect care staff and the etardation Professional on at approximately 3:00 PM lient had a repositioning pose of reducing skin irritation urther interview with the QMRP and not presented this protocol and/or provided training to the sure that this procedure was at his day program.  Idual Program Plan on at 2:00 PM revealed that Client in two minutes every hour wake to relief stress on the sacral area." The protocol tioning data check sheet in the positioning data check sheet are dated 2/23/07 did not detail oncerns and did not address the was no evidence that the even made aware of the group less Client #2's concern to	W	120	See responses to W120 on pag Additionally the QMRP will communicate all relevant infor regarding changes in programm Client #1 to ensure that the day meets the needs of Client #1 ar The Director of Programs will routine record audits to verify compliance.	mation ning for y program nd #2. conduct	11/01/2007 — Ongoing

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	G	COMPL		
	·	09G127	B. WIN	G		10/1	2/2007	
MY OWN	ROMDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE /ASHINGTON, DC 20019		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	(D PREFI) TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE	
W 120 W 140	reduce skin irritation According the Physical dated 11/15/06 skir problem and neede	n and skin breakdown. ical Therapy (PT) evaluation breakdown was an ongoing d ongoing monitoring.	W 1		See responses to W120 on page 2/	32		
	The facility must es	tablish and maintain a system indicomplete accounting of address entrusted to the facility on	•	40				
	Based on staff inter the facility failed to system that ensure accounting of client	s not met as evidenced by: view and review of records, establish and maintain a s a complete and accurate s' funds that are entrusted to of the four clients residing in						
	The findings include The facility failed to complete accountin funds.	ensure accurate and g of each clients personal			•			
	PM, interview with the personal bank of August 15, 2007 and made from the clienthe records did not everify how his monie the QMRP revealed the receipts are taken reconciled. Further	2007 at approximately 2:00 he QMRP and review of Client atement revealed that on withdrawal of \$475.00 was it's account. Further review of evidence any receipt(s) to es were used. Interview with that the system requires that en to their main office and Interview revealed that she documentation what the			1. The Residence Manager has sultoriginal receipts for the \$475.00 withdrawn from Client #1's bank on 8/15/2007, the receipts have be placed on file in the Administrativin Client #1's file. The Residence Manager will reconcile all withdrawn Client #1's within thirty defined the withdrawal of funds	account een ve office awals	10/22/2007 - ongoing	

STATEMEN AND PLAN (	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  A. QUILDING			(X3) DATE SURVEY COMPLETED		
		09G127	B. WING_		10/1	2/2007
MAME OF F	ROVIDER OR SUPPLIER		•	REET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROFICION OF THE APPROPRIEMCY)	ULD BE	(X\$) COMPLETION -DATE
	2. On October 12, PM, interview with the #2 personal bank stander from the clienthe records did not verify how his monie the QMRP revealed the receipts are taken reconciled. Further could not verify with monies were used.  3. On October 12, PM, interview with the #4 personal bank stander from the clienther records did not verify how his monies the QMRP revealed the receipts are taken reconciled. Further could not verify with monies were used.  483.420(d)(2) STAF CLIENTS  The facility must ensintereatment, negleinjuries of unknown immediately to the allogicals in accordance established procedu.	2007 at approximately 2:10 he QMRP and review of Client tatement revealed that on withdrawal of \$465.00 was ht's account. Further review of evidence any receipt(s) to es were used. Interview with I that the system requires that en to their main office and interview revealed that she documentation what the  2007 at approximately 2:20 he QMRP and review of Client atement revealed that on withdrawal of \$300.00 was it's account. Further review of evidence any receipt(s) to es were used. Interview with that the system requires that en to their main office and interview revealed that she documentation what the  F TREATMENT OF  sure that all allegations of ct or abuse, as well as source, are reported dministrator or to other ce with State law through res.  not met as evidenced by:	W 140	2. The Residence Manager has sul original receipts for the \$465.00 withdrawn from Client #2's bank on 8/15/2007. The receipts have be placed on file in the Administrative in Client #2's file. The Residence Manager will reconcile all withdrawn from Client #2's within thirty dathe withdrawal of funds  3. The Residence Manager has sul original receipts for the \$300.00 withdrawn from Client #4's bank on 8/15/2007. The receipts have be placed on file in the Administrative in Client #4's file. The Residence Manager will reconcile all withdrawn from Client #4's within thirty dathe withdrawal of funds  1-3 Additionally the QMRP will at reconciliations of client funds and all purchases prior to submission or receipts to Administrative Office.	account een e office awals account een e office account een e office account een e office account een account een e office account een e office account een account een e office account een en e office account een eon eon eon eon eon eon eon eon eon	10/22/2007 - ongoing 11/01/07 — Ongoing
}	Based on staff interv	new and record review, the			ĺ	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULYI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURV COMPLETED	
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		09G127	B. WING _		10/12/2	007
NAME OF P	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D) PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE C	(XS) OMPLETION DATE
W 153	facility failed to ensign and serious userported immediate agencies as require Chapter 35 Section  The finding include: The review of the fareports and interview Retardation Profession 2007 at 9:45 AM, report the following	ure that all injuries of unknown inusual incidents were sty to the governmental and by DC regulation (22 DCMR 3519.10)  s: acility's unusual incident w with the Qualified Mental sional (QMRP) on October 10, evealed the facility failed to	W 153	a. The unusual incident report for client #I July 8, 2007 has been investigated. Revier records indicates that Client #I was evaluated nurse on 07/08/2007 nursing notes state that apparent injury. Supporting documentation incident is maintained in Client #I's record received additional training on incident may which included the incident reporting process. The unusual incident report for Client #October 12, 2006 has been investigated. Rethe records indicated that there were no injustained to Client #I as a result of him slit the bed. Staff completed an incident report precautionary measure until he had been fit evaluated by a health care professional. Staff received training to reinforce appropriand transferring techniques.	w of sted by the cre was no a of this ds. Staff magement, ess.  I dated eview of uries ding off as a ally	1/01/07
	<ul> <li>2007, revealed Clie the staff to be swoll information available origin of this injury.</li> <li>b. An unusual inc 2006, revealed Clie</li> </ul>	ident report, dated July 8, nt #1 face was observed by en. There was no additional e to determine the unknown ident report, dated October 12, nt #1 was being assisted		c. The unusual incident report for Client #4 June 26, 2007 has been investigated. Supp documentation is maintained in client #4's The results of the investigation revealed the #4 had sustained the injury while at the day The origin of the injury was determined as reviewing day program record for Client #4 and discussion with st day program.	record. at Client program. a result of	1/01/07 vagoing
	the floor in his bedrinformation available negligent or if theer c. An unusual inci 2007, revealed Clie program with "scars neck". There was r	dent report, dated June 26, nt #4 arrived from his day on and near his ear and no additional information		d. The unusual incident report for client #1 November 11, 2006 has been investigated, of the investigation determined that the injusustained by the blinds in client #1's bedroop revent further injury the bedroom furniture repositioned. To date there have been no surccurrence.  a-d Additionally, QMRP will ensure that all incidents reports are generated to all pertine	Results Or	
	available to determine these injuries.  d. An unusual incident, 2006, revealed this right finger bleed	ne the unknown origin of dent report, dated November Client #1 was discovered with ding. There was no additional e to determine the origin of	·	and investigated according to policy and pro- tand investigated according to policy and pro- The Incident Management Coordinator will all incidents and follow-up to ensure agency adherence to incident management policy at procedures. A tracking system has been implemented to monitor timely submission investigative reports and pertinent document regarding the incident.	ncedure, review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU		G	COMPLETED	
	I	09G127	B. Wil	/C_	· · · · · · · · · · · · · · · · · · ·	10/12	/2007
NAME OF P	ROVIDER OR SUPPLIER			4	EET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE /ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
W 153	this injury. 483.420(d)(3) STAI CLIENTS  The facility must haviolations are thoro  This STANDARD Based on interview failed to ensure all of unknown origin with the findings includ Review of the facility book on October evealed the follow unknown origin we a. An unusual inception availability.  An unusual inception availability.  b. An unusual inception information availability injury.  b. An unusual inception in the following personal hyperior in his bedroom information availability in the following personal hyperior in the following p	FF TREATMENT OF  ave evidence that all alleged aughly investigated.  is not met as evidenced by: and record review the facility unusual incidences of injuries were thoroughly investigated.  e: ty's Unusual Incident Reports er 10, 2007 at 9:45 PM ing Incidents and/or injuries of re not been investigated:  cident report, dated July 8, ent #1 face was observed by There was no further alle to determine the origin of cident report, dated October 12, ent #1 was being assisted giene and fell off the bed to the n. There was no further alle to determine if staff were	W	153	a-c. Cross reference response to	W153.	I 1/01/07 — Ougoing
	neck". There was	no further information available igin of these injuries.		<b></b>	-		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A. BUII		CONSTRUCTION  G	COMPLE	
ļ		09G127	B. WIN	G_		10/12	2/2007
NAME OF P	ROVIDER OR SUPPLIER I PLAGE			41	EET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE /ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PRIEFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DAYE
W 154	d. An unusual inc 11, 2006, revealed his right finger blee information availab	ge 7 ident report, dated November Client #1 was discovered with ding. There was no further te to determine the origin of	W 1	54	d Cross reference response to W	153.	11/01/07 – Ongoing
W 159	RETARDATION PE Each client's active integrated, coordinated		<b>W</b> 1	59	1a-b. Cross reference response to #1-2.	W120	10/14/07- Ougoing
	Based on interview facility's Qualified M Professional (QMR	s not met as evidenced by: and record review, the lental Retardation P) failed to adequately and coordinate each client's					·
	The findings include	<b>a</b> :					
	services and suppo	d to coordinate outside rts for Client #1 and #2.		Į.	·		
	observed reposition allowed to stand with	survey direct care staff was ning Client #1. The Client was th staff assistance, to sit with to sit on the couch and to lay			·		-
	Qualified Mental Re October 11, 2007 a revealed that Client protocol in place for irritation and breake the QMRP revealed	irect care staff and the etardation Professional on t approximately 1:40 PM #1 had a repositioning reducing skin down. Further interview with a that she had not presented day program or provided					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	E CONSTRUCTION	COMPLE	ETED	
		09G127	B. Wil				2/2007	
NAME OF P	ROVIDER OR SUPPLIER			414	ET ADDRESS, CITY, STATE, ZIP COM 1 ANACOSTIA AVE, NE ISHINGTON, DC 20019	) E.		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ix	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 159	Continued From paraining to the day procedure was be program.  Review of the Ind October 11, 2007 #1 was required thours when he is delicate skin in his also included a reto be record whe Review of the recrepositioning data.  b. On October 1 was observed the Client #2. The Cambulate with his to sit in a regular Interview with the Qualified Mental October 11, 200 revealed that the protocol for the pand breakdown, revealed that she to the day program to being implement Review of the In October 11, 200 #1 was to "stanhours when he delicate skin in referred to a regular referred to a regular to a regular was to "stanhours when he delicate skin in referred to a regular was to a regular was to a regular was to "stanhours when he delicate skin in referred to a regular was to a regular	program to ensure that this sing implemented at the day ividual Program Plan on at 2:00 PM revealed that Client to be "repositioned every two awake to relief stress on the searcal area." The protocol epositioning check sheet for data in implementing this protocol. For a strength of the survey repositioning a from Client #1's day program. Of and 11, 2007 direct care staff roughout the survey repositioning elient was allowed to stand and to sawaker, to sit on the couch and rehair during his meals.  The direct care staff and the Retardation Professional on at approximately 3:00 PM are client had a repositioning burpose of reducing skin irritation. Further interview with the QMRF and not presented this protocol arm and/or provided training to the ensure that this procedure was ted at his day program.  Idividual Program Plan on the difference of the sacral area." The protocol positioning data check sheet.		159				
1	Review of the h	abilitation records, however did				•		

STATEMEN' AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII B. WIN	LDING	CON	E SURVEY PLETED 0/1 <u>2/2007</u>	ib .	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019					
(X4) ID PREFIX TAG	I /EACH DESIGNEN	STATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO DATE	МС	
W 159	not evidence the from the day proprogram Plan of any skin integrity repositioning. Tiday program had homes plan to a reduce skin irrite According the Platted 11/15/06 sproblem and nero c. October 11, interview with the Program Director of Client #2's curred that Cimedications at Inurse insisted the needed on file interview with the afternoon (appropriem the QMRP state physician's ordewas unable to vevidence.  2. The QMRP reflective of numerical interview with the trisphysician's physician's ph	repositioning data check sheet gram. Review of the day Care dated 2/23/07 did not detail reconcerns and did not address here was no evidence that the deen made aware of the group ddress Client #2's concern to ation and skin breakdown. Hysical Therapy (PT) evaluation skin breakdown was an ongoing added ongoing monitoring.  2007 at approximately 12:45 PM as day program Nurse and the prevealed that they were in need arrent physician's orders from wither interview with the nurse lient #2 did not receive his day program, however, the hat current medical information is nease of an emergency situation. The CMRP later that same oximately 2:30 PM) revealed that sician orders had been delivered to an on several occasion. Although, and that she delivered the rerify her delivery with documented failed to ensure diet orders were tritional changes to Client #1's		159	c. The QMRP has provided the day program a copy of the current physician orders for Client #2. A receipt for delivery will be obtained for all documents provided to the day program. Current Physician Orders will be provided to the day program on an ongoing basis. Delivery receipts will be maintained as a record of theses transactions in client records.  1a-c. Additionally the QMRP will communicate all relevant information regarding changes in programming for Client #1 and #2.  The Director Programs will conduct routine record audits to verify the QMR in monitoring, integrating and coordinating each client's active treatment.  2. The nutritionist assessed client #1 or 10/14/07. All diet assessments were reviewed by the PCP on 10/15/07. All physician's order forms have been reviewed and revised to reflect the corr diet orders. QMRP in conjunction withe delegating nurse will audit the client.	P 10/15/ Ongoi	- - - 5/07-	

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	CORRECTION IDENTIFICATION NUMBER: A. BUILDING		TED		
		09G127	B. WING		10/1	2/2007
NAME OF P	PLACE		5	STREET ADDRESS, CITY, STATE, 219 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019	CODE	
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 159	Continued From padlet. Further revier juice or prunes for daily and strictly for recommendations.  There was no evidual assessed the clier Review of the Apradiet order changes bite size texture. Communicated to 3. The QMRP fair ensure that each with adequate training employees to perform the performance of daily in the QMRP fair documented on its consistently. (See fair enderces of injusting the QMRP fair incidences of injusting the quality investing the property of the QMRP fair incidences of injusting the quality investing the quality inv	age 10 w of the order included prune snacks, prune or apple juice slow nutritionist dence that the nutritionist had ht's since her April 11, 2007. il assessment recommended a d to 2000 - 2400 calories and These changes were not the primary care physician. led to ensure that failed to employee had been provided ining that enables the form his or her duties. (See led to ensure that direct care topical treatment during living. (See W365) illed to ensure that direct care PP program objectives	W 15		a quarterly basis ing of Client's in conjunction e, will lended PCP as they icate ing the nutritional ing Nurse will ders to reflect approved by the onse to W189 on onse to W252 on aponse to W252 on aponse to W154 & of 32.	11/01/07 Ongoing  11/01/07 Ongoing  11/01/07 Ongoing  11/01/07 Ongoing
	8. The QMRP fa system that ensu	e governmental agencies as egulation. (See W153) illed to establish and maintain a tres a complete and accurate ents' funds that are entrusted to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G127	B. WII	NG		10/12/2007	
NAME OF P	ROMDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 41 ANACOSTIA AVE, NE IASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 159	the facility. (See V 9. The QMRP faile program were train repositionig protoc W120)			159	9. Cross reference response to W page 2/32.	120 on	, 11/01/07— Ongoing
	initial and continuing employee to perform frictionally, and continuing the street of	is not met as evidenced by: w and record review, the facility at each employee had been quate training that enables the form his or her duties effectively, appetently.					
	effectively trained provided his adap when propelling his observation on O revealed that Clie his wheelchair incostaff and record in revealed that Clie gloves to reduce Interview with the 2007 at approxim	lirect care staff falled to be to ensure that Client #3 was tive gloves to protect his hands is wheelchair.  ctober 10, and 11, 2007 nt #4 had the ability to mobilize lependently. Interview with the eview on October 12, 2007 nt #4 was to use protective	1		1. Review of the training recomindicated that staff had received on the proper use of gloves for including documenting refusals the gloves. The use of gloves ff #4 has been highlighted as a sup on his daily activity data sheet, sheet is maintained in his daily record. Staff will document the gloves when Client #4 is propel wheelchair. Residence Manage conjunction with QMRP will reobserve Client #4 to ensure that are used per PT recommendation.	I training Client #4 to wear or Client pport need The data program c use of lling his er in outinely t gloves	11/01/07 Ongoing

PRINTED: 10/25/2007 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING B. WING 10/12/2007 09G127 STREET ADORESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019 MY OWN PLACE PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG W 189 Continued From page 12 W 189 Review of Client #3's Physical Therapy assessment dated October 4, 2006 revealed a recommendation to continue the use of gloves for wheelchair propulsion as a measure to decrease calluses. At no time during the survey were direct care staff observed to encourage Client #3 to wear his gloves. 2. The facility's direct care staff failed to be 2. Staff have received additional training effectively trained to ensure that Client #1 and 11/01/07 in the use of adaptive equipment at Client #3's elevated tray was consistently used Ongoing mealtimes for Client #1 and #3. The use during each meal. of adaptive equipment for Client #1 and #3 has been highlighted as a support need Observation of the breakfast on October 10, 2007 on their daily activity data sheet. The at 7:43 AM revealed Client #1 and Client #3 eating independently using an adaptive built-up data sheet is maintained in their daily handle spoon and a high sided plates. Also program record. Staff will document the observed using the meal was a large amount of use of adaptive equipment at mealtimes. spillage on the counter surface. Residence Manager in conjunction with OMRP will routinely observe mealtimes Observation of the dinner at approximately 4:52 to ensure that adaptive equipment is in PM revealed Clients #1 and #3 eating use per OT recommendation. independently with their adaptive plante on an elevated wooden tray. There was minimal spillage observed. Interview with the house manager confirmed that both of these clients were required to use a wooden riser during meals to bring the plate closer to them and to reduce spillage while eating. Review of Client #1's Occupational Therapy (OT)

assessment dated 12/5/06 revealed a

recommendation to continue to use an elevated tray for meals to reduce spillage and distance from plate to mouth. Review of Client #3's OT assessment dated 12/5/06 recommended that

DEGART	MENT OF HEALTH	AND HUMAN SERVICES				PRINTED: 1 FORM A OMB NO. 0	PPROVED
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DTATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) ML A. BUIL		CONSTRUCTION	COMPLET	ĒD .
AITO FOR THE		09G127	a. WIN	G		10/12	2007
				STREE	T ADDRESS, CITY, STATE, ZIP CODE		ł
	ROVIDER OR SUPPLIER		,	4141	I ANACOSTIA AVE, NE SHINGTON, DC 20019		
MY OWN					-BOURDER'S REAN OF CORRE	CTION	(XS) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	uutu BE I	DATE
W 189	Continued From p	age 13	W	189			
	he should also cor	tinue to use an elevated tray to		1			10/17/07 —
{	reduce distance p	late to mouth.			3. Staff have received addition	ai training	Ongoing
1	a 0- 0-t-har 42	2007 at 11:00 AM interview			in the use of Support TED Hos	E GAMY TOP TED Hose	Cugono
l	with the house ma	Hader levesied man chemical			Client #1. The use of Support for Client #1 has been highligh	tey as a	
İ	I was required to W	AST SUDDOIT TOU NOST YANY.	ļ	1	support need on the daily activ	ity data	
ļ	I Cubbor intontious	with the house manager	Ì		sheet. The data sheet is mainta	ined in his	Ì
1	revealed that the	client was not wearing ted nose		1	daily program record. Staff wi	11	
	at that time and 9	stated that Client #15 Support		1	document the use of Support T	ED Hose	
	hose were in this	bedroom's side table drawer.	1	Ì	daily. Residence Manager in C	oniunction	
1	Daview of the Dh	ysical Therapist assessment	}		with QMRP will routinely obs	erve	}
1	I dated Sentember	· 28, 2006 reflected a		Ì	mealtimes to ensure that Suppo	ort TED	}
		that the client wear supportive		l	Hose is in use per PT recomm	endations.	
ļ	hose on his lowe	r extremities to reduce swelling	1	ľ	-		
<b>\</b>	during waking ho	ours. At no time during the	1				1
1	survey was Clien	t #1 observed wearing the			4. The TME was provided ad	lditional	<b>.</b>
1	supportive hose	as prescribed. It should be t Client #1 has a diagnosis of leg	, 1	ľ	instruction on appropriate me	diation	10/17/07- Ongoing
		( Client #1 (las a diagnosis vi vs	' <b> </b>		disposal on 10/17/07. The m	edication	Ongoing
1	edema.				administration policy (which	nicitines	
	4. The Trained I	Medication Employee (TME)	1		medication disposal procedur available at each home for sta	us) is iff reference	
	failed to impleme	ent agency nursing policy for			TME have been further instr		
}	disposal of Clien	it #1's medication.	ļ		contact the Delegating Nurse		}
			l		clarification of procedures as		
	Although the TV	IE commented during the	ıď		Commission of brondings and	<del></del>	
	medication adm	inistration that he had participate g for his license renewal on the	-		Routine refresher courses wil	1 be	
	day prior to the	survey, this training was not	1		provided to all staff certified	to	
	effective as evid	lenced by the following:			administer medications. The	Delegating	
				•	Nurse will perform routine m	edication	
-	Observation of 1	the medication pass on October	1		pass observations to identify	the need for	
	10, 2007 at 8:03	3 AM, revealed that the Trained			further training. Follow-up a	iction as	
	Medication Em	ployee (TME) was unable to nt #1's all of his AM medication	1		appropriate will occur in the	event of	
	regimen the Th	ME was only able to administer			repeated deviation from the	nedication	
	Client #1 Lectul	lose 60 ml. The TME made trie	e		administration procedures in	ciuding	
	additional atteπ	opts were made to admininstere of his medications, but was			suspension of medication ad privileges.	ministration	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	COMPLET	
		09G127	B. WIN	G		10/12	/2007
NAME OF P	ROVIDER OR SUPPLIER			414	ET ADDRESS, CITY, STATE, ZIP CODE 41 ANACOSTIA AVE, NË ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 189	unsuccessful.  The TME turned to medication pass a refusing his medic document in the M Record (MAR) the unconsumed pills. TME then picked ucontacted the nurshis medication. A conversation with pills in the zip lock bag in the kitchen.  Later that afternoot the Director of Nuragency policy of document circle the the front of the MA was not given. It reason for not giving the MAR. Further	o the surveyor during the and commented, "[Client #1] is ation". The TME proceeded to ledication Administration clients refusal and left the on the kitchen counter. The up the telephone and reportedly se to report Client # 1 refusal of After completing his telephone the nurse, the TME placed the bag and placed the zip lock garbage container.  In at 3:30 PM, interview with raing(DON) revealed that the isposal of medication is to first se date corresponding block on AR indicating the medication Next, the TME was to write the ng the medication on the back er interview with the nurse	w·	189			
W 216	secure and leave destroy; or 2) to fludrainage system at 5. The facility failed program was train #1 and #2 repositi 483.440(c)(3)(v) If the comprehensional destroys this STANDARD	rME has two options. 1) to the medication for the nurse to ush the medication down the and dcoumrnt it in the records.  Led to ensure that the day led in the implementation Client oning protocols. (See W120) NDIVIDUAL PROGRAM PLAN we functional assessment must evelopment and health.  Lis not met as evidenced by: erview and record review, the	w	216	Cross reference response to W1 page 2/32. See response to W216 on page		11/01/07 _ Ongoing

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
-		09G127	B. WIN	IG		10/12	/2007
NAME OF P	ROVIDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 216	facility failed to ensithe sample had an examination in prej functional assessman. The finding include Interview with the happroximately 1:30 records revealed the medical evaluation 2006. According to scheduled for the right primary care physician was facility next week. Support Plan meet 10/25/07. At the tidocumented evide medical assessma 483.440(e)(1) PROData relative to acceptified in client in	ure that one of the two client in annual physical health paration for his comprehensive lent. (Clients #1)	W 2	216	The annual Physical examination completed for Client #1 on 10/15. The physician has been provided calendar of all physical examination expiration dates to assist in ensurtimely examinations. The Delega Nurse, in conjunction with the QI will monitor the expiration dates physicals during her monthly nurreviews and follow-up with the pl to schedule all physical appointment their expiration.	/07. with a ion ing uting MRP, of all sing	10/15/07- Ongoing
	Based on observat review, the facility client's Individual F were documented the frequency requ	is not met as evidenced by: cions, interview and record failed to ensure that each Program Plan (IPP) objectives consistently, accurately and in ired by the IPP for two of the d in the sample. (Clients #1					-

GTATEME	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUII B. WIN	LDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 25	The findings inclu  1. The facility's magnetic document Client is self-medication of W371)  2. Interview the review on Octobe Client #2 had an exercise program exercise for 5 daymonths" The program of the day september reflection of documenting	de:  dedication nurse failed to f2's participation in his ojective consistently. (See house manager and record at 11, 2007 at 11:00 AM revealed objective to participate in an with 5 repetitions of each ys per week for 12 consecutive gram implementation was ta sheets for the month of cited that direct care staff were data consistently as required by	W	252	1. All medication nurses readditional training on compredication objective docur 10/30/07 for Client #2. All nurses will document the so objective data as outlined individual self-medication recommendations. The QM review the data sheets weel progress/participation in so objectives. QMRP will into f progress in the monthly The Delegating RN will me completion of data during review of the MAR documentation of the data that the records to me consistent documentation medication objectives and	oleting the self- mentation on I medication elf-medication in the assessment IRP will kly to monitor elf-medication clude a report QMRP notes. conitor the the weekly mentation. The as and Programs conitor for of the self follow up as	10/30/07- Ongoing
. w	review on Octobe Client #2 had an in the residence using the roller warralls." The prog client participation Friday.  Review of the dasseptember reflerence documenting the data frequer 483.440(f)(3)(iii) CHANGE	house manager and record er 11, 2007 at 11:20 AM revealed objective to walk twenty (20) feet every two (2) hours while awake valker for four(4) out of four (4) ram implementation required the on on Monday, Wednesday and ata sheets for the month of cted that direct care staff were data consistently as required by		√ 26	necessary for any discrepa 2-3. Staff has received add on completing the docume required for Client #2's ex on 10/27/07. Residence of conjunction with the QMI data sheets weekly for condocumentation and observing implementation as require frequency schedule. Staff provided ongoing training the documentation is reco- consistently. Evidence of observation will be reflect QMRP monthly progress	ditional training entation exercise program manager in RP will review existent we program ed by data f will be g to ensure that orded freview and exted in the	10/30/07- Ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUILDING			COMPLETED		
	•	09G127	E, WIN	1G	·	10/12	/2007
NAME OF P	ROMDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE VASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of deficiencies Must be preceded by full SC identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETION OATE
W 264	programs as they restraints, time-out or noxious stimuli, behavior, protection any other areas the to be addressed.  This STANDARD Based on observat	elate to drug usage, physical rooms, application of painful control of inappropriate in of client rights and funds, and at the committee believes need is not met as evidenced by: ion, staff interview and record	W:	264	The physician has reviewed the of the use of bedrails for Client and has recommended their cont	#1 and #3	10/29/07-
	failed to reviewed, of bed rails for two Clients #1 and #3.  The finding include During the environ October 11, 2007 and Clients #1 and #3 rails on their beds. manager revealed when the client's wasfety.  Review of habilitate to provide the reas and #3's beds. At minutes were not a rails had been revictients #1 and #3. did not evidence pafety while in a best to should be noted revealed that Client finger bleeding and	mental walk-through on at approximately 5:30 PM, were observed to have bed Interview with the house that the bed rails were used ere in their beds for their on and medical records failed on for using rails on clients #1 the time of the survey, HRC available to determine if the bed ewed, approved or monitor for Further review of the records recedures for ensuring client			as a safety precaution. A procedensuring client safety while in be bedrails has been developed and will be provided on the protocol Physical therapist on 11/31/07. interim, staff received training of 10/17/07 that was conducted by Delegating Nurse, on procedure ensuring client safety while in bedrails. The physician's recommendation for the use of the has been reviewed and approved HRC on 10/29/07. The QMRP received additional training on situations require HRC review. will review all potential risks to of the clients (including but not the use of bedrails) with the esta Human Rights Committee for recommendations, approval and monitoring. Evidence of the H review will be maintained in the records and in the administrative	ture for ed with I training I by the In the In the on the ss for ed with bedrails d by the has what QMRP the rights limited to ablished I RC c Client's that are	Ongoing

PRINTED: 10/25/2007 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES ФМВ NO. 0<u>938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 10/12/2007 09G127 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4141 ANACOSTIA AVE, NE MY OWN PLACE WASHINGTON, DC 20019 (XS) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ΙĐ SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 264 Continued From page 18 W 264 Additionally, the Director of Operations Another incident reported that Client #1 slide out has developed an annual HRC committee of his bed onto the floor while direct care staff meeting calendar and submitted it to all was assisting him with personal hygiene activities. committee members. Minutes of all HRC [See W153] meetings will be maintained by the Director of Operations in the The facility's Human Rights Committee minute for administrative office. Copies of the HRC the past 12 months were not available for review minutes will be distributed to the homes at the time of the recertification survey. to be filed (as applicable) in all Client's W 322 483.460(a)(3) PHYSICIAN SERVICES W 322 record. The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventive care. 10/15/07-1. Cross reference response to W216 on Ongoing page 16/32. The findings include: 11/21/07-2. A follow up ENT appointment for Ongoing 1. The facility failed to ensure that Client #1's Client # 2 has been scheduled for annual physical assessment was completed. (See 11/21/07. W216) .11/30/07-3. The usual dental provider for Client #2 2. Interview with the nurse and review of Client Ongoing abruptly stopped accepting DC Medicaid. #2's medical records on October 11, 2007 at The agency provider has subsequently approximately 11:30 AM revealed an Ear, Nose and Throat (ENT) consultation occurred on March secured the services of an alternate dentist. Dental evaluation will be 20, 2007 with a recommendation to return September 2007. Further review of the medical completed by 11/30/07 A list of dental records failed to reflect a follow-up appointment providers has been secured as a reference had been scheduled. to ensure uninterrupted dental service provision in the event that the current

W352)

3. The facility failed to ensure that Client #1 was

seen by a Dental consultant as required. (See

The facility failed to ensure safety measures

#2's benefits.

dental provider no longer accepts Client

	OF DEFICIENCIES OF CORRECTION	(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		09G127	B, WING		10/1	2/2007
MY OWN	ROVIDER OR SUPPLIER		}	TREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NË WASHINGTON, DC 20019		•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 322	were in place for the rails.  Ouring the environm October 11, 2007 a Clients #1 and #3 wrails on their beds. manager revealed to when the client's we safety.  Review of habilitation to provide the reason and #3's beds. At the minutes were not arrails had been review Clients #1 and #3. did not evidence prosafety while in a beautiful to be bed in a beautiful to the was assisting him we said that Client #3.  The facility's direct that Client #3 was provided that the client #3 was provided that Client #3	nental walk-through on tapproximately 5:30 PM, were observed to have bed Interview with the house that the bed rails were used are in their beds for their on and medical records failed an for using rails on clients #1 the time of the survey, HRC vailable to determine if the bed twed, approved or monitor for Further review of the records occodures for ensuring client	W 32		the dical  ine  atus of ed and w up  ated to items  crvices corm is ealth  ition will arrse with the ellations, by be for	Ongoing  10/29/07- Ongoing
	revealed that Client his wheelchair inde staff and record rev	ober 10, and 11, 2007 #4 had the ability to mobilize pendently. Interview with the iew on October 12, 2007 #4 was to use protective nd calloses.				

PRINTED: 10/25/2007

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G127 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4141 ANACOSTIA AVE, NE MY OWN PLACE WASHINGTON, DC 20019 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X6) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX COMPLETION TAG TÀG DEFICIENCY) W 322 Continued From page 20 W 322 Interview with the house manager on October 11, 2007 at approximately 4:30 PM revealed that the adaptive support gloves were in the night stand in his bedroom. Review of Client #3's Physical Therapy assessment dated October 4, 2006 revealed a recommendation to continue the use of gloves for Wheelchair propulsion as a measure to decrease calluses. At no time during the survey were direct care staff observed to encourage Client #3 to wear his gloves. 6: On October 12, 2007 at 11:00 AM interview Ongoing 6. Cross reference response to W189 #3. with the house manager revealed that Client #1 was required to wear support ted hose daily. Further interview with the house manager revealed that the client was not wearing ted hose at that time, and stated that Client #1's support hose were in this bedroom's side table drawer. Review of the Physical Therapist assessment dated September 28, 2006 reflected a recommendation that the client wear supportive hose on his lower extremities to reduce swelling

W 331

The facility must provide clients with nursing services in accordance with their needs.

483.460(c) NURSING SERVICES

during waking hours. At no time during the survey was Client #1 observed wearing the supportive hose as prescribed. It should be further noted that Client #1 has a diagnosis of leg

This STANDARD is not met as evidenced by: Based on observation, interview and record

edema.

W 331

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUII		G	COMPLE	
		09G127 .	B. WIN	IG_		10/12	2/2007
NAME OF P	ROVIDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 41 ANACOSTIA AVE, NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC [EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	review, the facility to services in accordance clients residing in the The findings included	ailed to provide nursing ince with the needs of the nis facility.	w s	331	<ol> <li>Cross reference response to W</li> <li>Cross reference response to W</li> </ol>	/322 #2. /322 #3	11/01/07 ~ Ongoing
	Client #2 had a EN scheduled. (See W. 2. The facility nurs Client #2's had a d (See W352)  3. The facility's nureach client were proports as recomw436)	ing staff failed to ensure that ental appointment scheduled.  rsing staff failed to ensure that ovided usage of adaptive ended. (See W189 and			3. Cross reference response to W W436.	7189 and	Ongoing
W 343	Nurses providing s a current license to This STANDARD Based on staff inte	ervices in the facility must have practice in the State.  is not met as evidenced by: rview and record review, the sure that all nurses providing	w:		The professional license to prace District of Columbia for the LPI has been obtained and is on file conspicuous manner per HORA guidelines. A copy of all Delega Nurses, LPN's professional licente maintained by the Director of Services. The Director of	N ( ) in a ating asses will thealth	10/17/07- Ongoing
,	services in the faci practice in the Dist The finding include Interview with the C Professional (QMF on October 11, 200 medication nurse it consultant file. Re	lity had a current license to rict of Columbia.			Services. The Director of Health will maintain a spreadsheet of the expiration dates of all Nursing li Notification of expiring, expired absent documents will be forwar the pertinent individuals along we deadline for submission. In the efficiency the requested documentation is not submitted, consequential action a appropriate will occur including suspension of duties until such the required documents are submitted to the required documents are submitted.	e censes. , or ded to ith a vent that ot us	-

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	LDING	(X3) DATE S COMPL	
		09G127	B. WIN	IG	10/1	12/2007
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019	:ODE	
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W 343	Continued From pa	ge 22	W 3	343	<b></b>	
W 352	survey that the LPN practice in the Distr with the Health Occ Title 3 Chapter 12 slicensee shall display and all places the licensee.") 483,450(f)(2) COM DIAGNOSTIC SER	ntal diagnostic services amination and diagnosis	w s	Cross reference response to page 19/32.	W322 #3 on	·
	Based on observati review, the facility f	•				
W 365	Interview with the medical records on approximately 11:5 consultation was a dental appointment 483.460(j)(4) DRUG	ourse and review of Client #2's October 11, 2007 at O AM revealed his last dental completed March 21, 2005. ith the nurse revealed that a May 19, 2007 consultation nedical book, however the ts were not completed. G REGIMEN REVIEW	ws	365		
	L	1		•		

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	١, ,	LDING	LE CONSTRUCTION	COMPLE	
		09G127	B. WI	4G		10/1	2/2007
NAME OF P	ROVIDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 41 ANACOSTIA AVE, NE ASHINGTON, DC 20019	<b>£</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	אוי	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 365	This STANDARD Based on staff into facility failed to est that ensures that	is not met as evidenced by: erview and record reviews, the tablish and maintain a systems an individuals medication ntained for two of the two in the	W	365	See response to W365 on page	: 24/32.	
	documentation of administration in a	de:  ed to ensure its system for Client #1's medication accordance with the agency's ures as evidence by the	•		1a-g. The documentation error #1 and #2 were corrected on 1 Review of the medication blist interview with the staff reveale medication had been given but documented on the MAR.	0/15/2007. ter pack and ed that the	10/30/07- Ongoing
	Record (MAR) aff observation on Ocapproximately 8:4  a. On 10/7/07 the Gel Tablets had nadministered.  b. On 10/7/07 the 750mg had not be administered.  c. On 10/7/07 the Acid 25 mg had nadministered.  d. On 10/7/07 the administered.	H's Medication Administration for the medication pass ctober 10, 2007 at 5 AM revealed the following: e client's PM dosage of Senna for been signed as being e client's PM dosage of Keppra feen signed as being e client's PM dosage of Valproic for been signed as being e client's PM dosage of Valproic for been signed as being			The Director of Health Service provided all medication nurses TME's additional training on a documentation of medication administration. Staff have been on correct procedures for documedication omission on the M Training was completed on 10 The delegating RN will review at least once weekly to monite documentation.  Follow-up action as appropriat occur in the event of repeated from the approved medication administration procedures inclusively action and privileges.	s and accurate  n instructed umenting a (AR. 0/30/2007. w the MAR or  te will deviation luding	
		e client's PM dosage of 60 ML not been signed as being					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		0 <b>9</b> G127	B. WIN	<u>.                                    </u>	-	10/1:	2/2007
NAME OF P	ROVIDER OR SUPPLIER			414	ET ADDRESS, CITY, STATE, ZIP CODE 41 ANACOSTIA AVE, NE ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 365	f. On 10/7/07 the community of the cleanser and warm signed as being administed as bei	client's PM dosage of Aspirin sid 25 mg had not been signed red.  client's PM topical treatment compress had not been ministered.  urse on 10/11/07 at 11:00 AM medication were administered 0/7/07, however the nurse her administration.  dication Employee (TME)  Client #1's refusal of his y in the MAR in accordance itcy and procedures.  esignated nurse on 10/11/07  45 PM revealed that the TME Client #1's refusal of his ion regimen in the progress cation Administration Records.  ninistered Client #1 60 ml of incorrectly documented this had not been administered.  ON the TME was to have for the date refused and initial ne was to document on the not then write a progress note incate to the nurse to reordered equately account for were destroyed.  If to ensure its system for client #1's topical treatment			2. TME's have received further tron the proper disposal of wasted mediation and appropriate docum procedures and have been remind the Medication Administration Tr manual's location to use as a refer Training was completed on 10/30. The delegating RN will review that least once weekly to monitor documentation. Additionally, the residence has been provided with medication administration referen manual. Follow-up action as appropriate woccur in the event of repeated deviron the approved medication administration procedures including suspension of medication administration privileges	nentation ed of aining rence. /2007. e MAR  a ce rill iation	10/30/07- Ongoing
ı		Client #1's topical treatment tered by the direct care staff					

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(XC3) DATE SU COMPLE	
		09G127	E. WIN	IG		10/1	2/2007
NAME OF P	ROVIDER OR SUPPLIER			41	ET ADDRESS, CITY, STATE, ZIP CODE 41 ANACOSTIA AVE, NE ASHINGTON, DC 20019	i	
(X4) ID PREFIX YAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 365	were implemented agency's policy and below:  June 2007 Ammon Apply to legs every topical treatment in administered.  July 2007 Ammon Apply to legs eveny topical treatment in administered.  August 2007 Ammon Cream(GM) Apply	in accordance with the disprocedures as evidenced in accordance with the disprocedures as evidenced in acctate 12% Cream(GM) y day at 7:00 AM - 30 days nedications were not y day at 7:00 AM - 11 days nedications were not in onlum Lactate 12% to legs every day at 7:00 AM - eatment medications were not	<b>W</b> :	365	3. Staff has received additional training instruction of the proper procedures for topical treatment medications on the a record. The treatment/topical medication administration record will be maintain book as opposed to the program record monitoring.  Additionally the QMRP will review the administration sheets weekly to monit documentation of topical medications. Delegating RN will monitor the topica records during the weekly review of the documentation.  Follow-up action as appropriate will one event of repeated deviation from the a medication administration procedures suspension of medication administration.	or documenting doministration con con con con con con con con con c	10/30/07- Ongoing
	october 2007 Am Cream(GM) Apply 4 days topical tres administered.  Note: Client #1's in the Skin as a minister that "Staff are to contreatments on the 4. The facility fail documentating the nutritional suppler medication nurse.  On June 10 2007	Staff treatment MAR was not w.  monium Lactate 12% to legs every day at 7:00 AM - atment medications were not  Health Management Care Plan isk area [decubitus ulcers] noted focument application of topical MAR as per physician orders."  ad to ensure its system for the administration of Client #2's ment was administered by the in as evidenced below:  the MAR reflected that Client #2 ered his dosage of Calcarb w			4. Further review of the MAR and dis staff revealed that the medication was because it was not available at the tim medication administration.  The Director of Health Services has p medication nurses and TME's addition accurate documentation of medication administration. Staff have been instruprocedures for documenting a medica on the MAR. Training was completed 10/30/2007. The delegating RN will in MAR at least twice per month to mon documentation.  Follow-up action as appropriate will of event of repeated deviation from the a medication administration procedures suspension of medication administration.	omitted e of  rovided all n training on ted on correct tion omission on review the itor  cccur in the pproved including	10/30/07- Ongoing

	BTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION	COMPLETED	
		09G127	B. WING _		10/1	2/2007
NAME OF P	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP C M41 ANACOSTIA AVE, NE WASHINGTON, DC 20019	ODÉ	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y NUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE
W 365 W 371	Vitamin D 600/200 PM. There was no medication nurse of	tablet at 7:00 AM nor at 6:00 reason given by the	W 365	·		
VV 37 1	The system for dru that clients are tau medications if the determines that se	ug administration must assure ght to administer their own interdisciplinary team elf-administration of medications objective, and if the physician		Cross reference response to page 17/32.	W252 on	10/30/07- Ongoing
-	Based on observa review, the facility system to provide self-administration	is not met as evidenced by: tion, staff interview and record failed to establish an effective a training program for of medication for one of the sample. (Client #2)				
	10 2007 at approx participated in his punching out his r	es: e medication pass on October timately 5:05 PM, Client #2 self-medication objective by nedications from the bubble the medication nurse.				
	11 2007 at approx medication nurse implementing the evening and docu	nurse and QMRP on October dimately 3:30 PM revealed the was responsible for self-medication objective in the menting the clients participation his data sheet in the MAR.			·	
	failed to evidence objective had bee	R for the month of October that Client #2 self-medication n implemented. Additionally, the Client #2 participating in his				

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	JUTIPLE CONSTRUCTION	(X3) DATE	
				·	-	LLILD
NAME OF	50.01.50.50.50.51.51.51	09G127	B. WIN	<u> </u>	10/	12/2007
1	PROVIDER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP 4141 ANACOSTIA AVE, NE WASHINGTON, DC 20019	CODE	.==••
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFD TAG	PROVIDER'S PLAN OF	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
W 371	Continued From pa	nge 27	E W		· <del>'</del>	<del> </del>
W 382	self-medication pro evening was not read 483.460(I)(2) DRUG RECORDKEEPING	gram on 10/10/07 in the corded.	W 38	Staff trained in medication will receive additional inst	ruction in	10/20/07
	administration.	being prepared for		maintaining the security of Staff are required to ensure medication cabinets are loo medications are not being	medications.  that the  ked when  prepared. A	
	Based on observation	s not met as evidenced by: on, the facility failed to keep all is locked securely when not administration.		notice staff of this protocol posted in a conspicuous loc reminder for staff. The delegating RN and QN	cation as a	
	The finding includes			randomly monitor medicate ensure medications remain times.	on passes to secure at all	
	medications and top were secured in acc	ensure that each client's ical treatment medications ordance with the agency's es as evidence by the		times.		
	closet located in the the key in the door.	bber 10, 2007 between 3:55 baled that the medication kitchen was left open with During this period, direct care er agency personnel were the kitchen.				·
	arrival into the facility inform the Program I the nurse in the facilithat time locked the of from the door.	oted that the house manager on closet open upon his . He then was observed to Director and question if the ty. The House Manager at closet and removed the key				
W 421	483.470(b)(4)(iv) CLI	ENT BEDROOMS	W 421			

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G127	B. WI	NG		10/12/2007	
NAME OF PROVIDER OR SUPPLIER  MY OWN PLACE				4	REET ADDRESS, CITY, STATE, ZIP CODE 1141 ANACOSTIA AVE, NE NASHINGTON, DC 20019		1212001
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A		DULD BE COMPLETION	
	Continued From parthe facility must proindividual closet spawith clothes racks a client.  This STANDARD is Based on observation facility failed to provide accessible for two of facility. (Client #1 and The finding includes  On October 11, 200 #3 personal clothing in a hall closet outsid Interview with the Hocolient #1 and Client: in their bedroom in oclothing.  Review of the inside revealed clothing whaccording to the Hocolothing.  Review of the inside revealed clothing whaccording to the Hocolothing.  Review of the inside revealed clothing whaccording to the Hocolothing.  The facility must furn and teach clients to us choices about the uschearing and other colients are clients and teach clients to us the aring and other colients and teach clients to us the aring and other colients and teach clients to us the aring and other colients and teach clients to us the aring and other colients and teach clients to us the aring and other colients and teach clients to us the aring and other colients and teach clients to us the aring and other colients and the aring and other colients and teach clients to us the aring and other colients and teach clients to us the aring and other colients and teach clients to us the aring and other colients.	ge 28  ovide each client with ace in the client's bedroom and shelves accessible to the  s not met as evidenced by: on and staff interview, the ide clothes racks and shelves if the four residing in the ad #3)  c at 5:00 PM, Client #1 and were observed being stored de of their bedroom. ousemanager revealed that #3's did not have a wardrobe ander to store their personal labels of several shirts ich belonged to Client #2, use Manager, Client #2 had However, the house provide a copy of a personal ocumentation of these items ther Client #1 or #3. E AND EQUIPMENT  ish, maintain in good repair, use and to make informed e of dentures, eyeglasses, mmunications aids braces	W 43	421	DEFICIENCY)	dressers coms storage. n is a ned to t's #1 en ations. ed to or ect the has tation to 3 has all idence nal hased	11/30/07  10/21/07-Ongoing
ľ	and other devices ide	entified by the as needed by the client					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
	•	09G127	B. WI	NG		10/12/2007	
NAME OF P	ROVIDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 141 ANACOSTIA AVE, NE /ASHINGTON, DC 20019		
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TO		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ついしひ おE	(X\$) COMPLETION DATE
W 436	W 436 Continued From page 29		W	436			
	Based on observation review, the facility	is not met as evidenced by: tion, interview and record failed to provide adaptive of the four clients residing in s #1, #3 and #4)			Cross reference response to V     Cross reference response to V	V189 #1. V189 #2.	11/1/07- Ongoing
	The findings include	•					
	that Client #3 was	rect care staff failed to ensure provided his adaptive gloves to when propelling his wheelchair.					
·	Observation on October 10, and 11, 2007 revealed that Client #4 had the ability to mobilize his wheelchair independently. Interview with the staff and record review on October 12, 2007 revealed that Client #4 was to use protective gloves to reduce hand calloses.						
	Interview with the house manager on October 11, 2007 at approximately 4:30 PM revealed that the adaptive support gloves were in the night stand in his bedroom.						
	assessment dated recommendation to wheelchair propuls calluses. At no fin	Client #3's Physical Therapy ont dated October 4, 2006 revealed a ndation to continue the use of gloves for a propulsion as a measure to decrease At no time during the survey were direct observed to encourage Client #3 to players.					-
	Client #1 and Clie	rect care staff failed to use nt #3's elevated tray g each meal for independence.					
		e breakfast on October 10, evealed Client #1 and Client #3					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		09G127	B. WING				2/2007
NAME OF P	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CO 141 ANACOSTIA AVE, NE VASHINGTON, DC 20019	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREF TA(	ix:	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
W 436	eating independent handle spoon and observed using the spillage on the could be purely and revealed Client independently with elevated wooden to spillage observed. Interview with the both of these client wooden riser during closer to them and eating.  Review of Client # assessment dated recommendation tray for meals to refrom plate to mou assessment dated he should also correduce distance put the should be	tly using an adaptive built-up a high sided plates. Also a meal was a large amount of inter surface.  I dinner at approximately 4:52 ts #1 and #3 eating their adaptive plante on an ray. There was minimal thouse manager confirmed that ts were required to use a greals to bring the plate to reduce spillage while to reduce spillage while to continue to use an elevated educe spillage and distance th. Review of Client #3's OT in 12/5/06 recommended that intinue to use an elevated tray to	W	436	3. Cross reference response	to W189 #3.	11/1/07-Ongoing
	recommendation hose on his lower	that the client wear supportive extremities to reduce swelling urs. At no time during the					

NAME OF PROVIDER OR SUPPLIER  MY OWN PLACE  STREET ADDRESS, CITY, STATE, ZIP CODE  4141 ANACOSTIA AVE, NE  WASHINGTON, DC 20019  (X4) ID  PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 436  Continued From page 31  Survey was Client #1 observed wearing the supportive hose as prescribed. It should be further noted that Client #1 has a diagnosis of leg edema.  W 440  483.470(i)(1) EVACUATION DRILLS  W 440  Review of the fire drill record evidences	COMPLETED	
NAME OF PROVIDER OR SUPPLIER  MY OWN PLACE  STREET ADDRESS, CITY, STATE, ZIP CODE  4141 ANACOSTIA AVE, NE  WASHINGTON, DC 20019  (X4) ID  PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 436  Continued From page 31  Survey was Client #1 observed wearing the supportive hose as prescribed. It should be further noted that Client #1 has a diagnosis of leg edema.  W 440  483.470(i)(1) EVACUATION DRILLS  W 440  Review of the fire drill record evidences	10/12/2007	
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 436  Continued From page 31  Survey was Client #1 observed wearing the supportive hose as prescribed. It should be further noted that Client #1 has a diagnosis of leg edema.  W 440  W 440  Review of the fire drill record evidences	•	
survey was Client #1 observed wearing the supportive hose as prescribed. It should be further noted that Client #1 has a diagnosis of leg edema.  W 440 483.470(i)(1) EVACUATION DRILLS  W 440 Review of the fire drill record evidences	(X5) COMPLETION DATE	
The facility must hold evacuation drills at least quarterly for each shift of personnel.  that fire drills have occurred during the period of October 2006 to June 2007 between the periods of 7am-3am. A fire drill schedule is maintained in an effort to	10/12/07- Onging	
This STANDARD is not met as evidenced by: Based on review of fire drill records, the facility failed to hold evacuation drills at least quarterly for each shift of personnel.  ensure that fire drills are conducted once monthly per shift. Fire drills will continue to occur during varied times and under varied conditions. Residence Manager and QMRP will review the fire		
The finding includes:  Interview with the House Manager on October 12, 2007, at approximately 10:55 PM revealed that the staff shifts are as follows:  drill records monthly to monitor completion of drills according to policies.  Fire safety training will be conducted at a minimum of annually for all staff.		
Review of the fire drill log revealed that the facility failed to hold fire evacuation drilfs for all shifts at least quarterly. There were no fire drills conducted were required within the follow periods:		
7:00 AM - 3:00 AM Monday through Sunday for the period of October 2006 to June 2007	_	
These above findings were referred to the Office of the Fire Marshall.		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) FROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:  09G127		(X2) MULT A. BUILDIN B. WING		COMP	(X3) DATE SURVEY COMPLETED 10/12/2007			
NAME OF P	ROVIDER OR SUPPLIER		STREET A	DORESS, CITY, S	STATE, ZIP CODE	10/	1212007		
MY OWN				NACOSTIA AVE, NE INGTON, DC 20018					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE			
1 000	INITIAL COMMEN	TS		1 000		-			
	10, 2007 through C sample of two clier	was conducted from October 12, 2007. A Its was selected from male clients with vary ites.	random a client						
1 043	3502.2(c) MEAL SI	ERVICE / DINING AF	REAS	1 043			,		
	Modified diets shall	l be as follows:			Cross reference response	to federal			
	(c) Reviewed at lea	est quarterly by a diet	itian.		deficiency report citation	W159 #2.	11/1/07		
·	Based on interview GHMRP failed to emodified diet are be	met as evidenced by and record review, the name of the prescribing monitored quarter or residents in the sare)	he ibed erly by a						
	The findings include	e: :							
	interview with the n #1's physician's ord 1500 calorle high fil diet. Further review	107 at approximately ourse and the review of the dated 9/1/07 reverser, low fat, low choice of the order includes snacks, prune or applice nutritionist	of Client aled a esterol d prune				-		
	assessed the client Review of the April diet order changed bite size texture. The	ence that the nutrition is since her April 11, assessment recomm to 2000 - 2400 calor hese changes were n te primary care physic	2007. lended a les and lot						
.	Further review of his	s medical records fail	led to						
	tion Administration								
					TITLE		(X8) DATE		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		0 <u></u> 9G127		B. WING_		10/12/2007			
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE					
MY OWN PLACE WASHIN			WASHING	ACOSTIA AVE, NE GTON, DC 20019					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
1 043	Continued From pa	ge 1		1 043					
	evidence any additional quarterly monitoring was occurring by the nutritionist to ensure the correct modified diet was being implemented to meet Resident #1's nutritional needs.								
.   058	3502.16 MEAL SEF	RVICE / DINING ARE	EAS.	1 058					
	A review and consultation by a dietitian or nutritionist shall be conducted at least quarterly to ensure that each resident who has been prescribed a modified dist receives adequate nutrition according to his or her Individual Habilitation Plan.				Cross reference response to feder deficiency report citation W159 #		11/30/07		
·	This Statute is not met as evidenced by: Based on interview and record review revealed that the facility's dietitian failed to conduct quarterly monitoring of special/modified diets.								
	The findings include	<b>:</b>			<u>.</u>	•			
	nutritional status wa evidenced below:	to ensure that Resid as monitored quarter ency Report Citation	y as	!					
1 077	3503.5 BEDROOM	S AND BATHROOM	s	1 077	_				
,	Each bedroom shall space for each residual clothing and person	l contain sufficient st dent ' s seasonal, pe al effects.	orage rsonal		Cross reference response to feder deficiency report citation W421.	al	11/1/07		
	Based on observation Group Home for Me	met as evidenced by on and staff interview entally Retarded Pers ensure ample storag	v, the						

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		09G127	,	B. WING_	· · · · · · · · · · · · · · · · · · ·	10/12/2007	
NAME OF P	ROMDER OR SUPPLIER				STATE, ZIP CODE		
				COSTIA AV			···
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
1 077	Continued From pa	ige 2		l <b>077</b>			
	in their bedroom for resident 's clothing for two of the four residents residing in the facility. (Resident #1 and #3)					·	
	The finding include			•			
	[See Federal Defici	iency Citation W421]					
1 090	3504.1 HOUSEKEEPING			1090			
	The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.						
	Based on observati GHMRP failed to m	met as evidenced by ion and staff interview raintain the facility in and sanitary manner.	w, the a		The missing handles on the C	Thousand Thousand	10/29/07
	The findings include	•			drawer for Resident #1 have bee replaced.	n	
	Internal		·		2 The handles on the Chester de Resident #3 have been replaced.	1	11/30/07
	The Chester dramissing handles.	wer for Resident #1	was		3. The wall behind Resident #1's scheduled to be repaired. 4. Cross reference response to feether.	1	11/30/07
	2. The Chester dramissing handles.	awer for Resident #3	was ,		deficiency report citation W421. Additionally, QMRP will ensure weekly environmental inspection	that	
	3. The wall behind damaged with stream	Resident #1 bed wa aks.	s		completed by the Residential Director/Designee. All maintenan concerns will be forwarded to the	nce	
	4. Resident #1 and #3 had no storage space in their bedroom for personal clothing. Their clothing was observed in a closet in the hallway outside of the bedroom.			5	Director of Operations and additional department heads as necessary for up action/correction of all mainted concerns.	ional or follow	
Health Regul	ation Administration						· · · · · · · · · · · · · · · · · · ·

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		A BUILOII	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED			
<u> </u>	·	09G127		B, WING		10/1	10/12/2007	
NAME OF P	ROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE				
MY OWN	PLACE		4141 ANA WASHING	COSTIA AV	VE, NE 20019			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
1 090	Continued From page 3 External  1. The garage areas was being used for storage.		1 090	The garage is not utilized as a egress in the event of an emergen items in the garage will be moved stored in an alternative location.	cy. The	11/30/07		
	propelled into the ga items were being st hazard.	he light fixture in the garage were not		·	2. The dryer exhaust will be re re expel lint outside of the home. The Director of Operations will secure contractor to complete the necess action. In the interim, the items is been moved out of range (10/17/6).	he e a ary nave 07) of	10/29/07	
	4. Four (4) areas w wood on ramp leadi be possible trip haza				the dryer exhaust pipe to prevent possible fire hazard.  3. The light fixture in the garage been repaired.		11/30/07	
	basement exit door	had trash, debris an drainage stoppage a	d leaves		4. The slats on the deck leading to driveway are scheduled to be repl	o the aced.	11/30/07	
J 095	3504.6 HOUSEKEE	_		1 095	5. The trash, debris and leaves or stairs leading from the driveway he been removed. The stairs are swe	ave	10/12/07- Ongoing	
	Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident.		ct reach		daily basis to prevent accumulation leaves and other debris that may be daily as a result of the seasonal clanges.	n of low in		
	Based on observation failed to lock caustic	agents being stored	GHMRP		Additionally, QMRP will ensure t weekly environmental inspections completed by the Residential Director/Designee. All maintenan	аге	-	
	The finding includes During the environm October 11, 2007 ap revealed the following	ental walk-through opproximately 5:24 PN	ori M		concerns will be forwarded to the Director of Operations and addition department heads as necessary for up action/correction of all mainter	onal follow		
	<ol> <li>Caustic agents w washer and dryer un</li> </ol>	ere being stored ove llocked.	er the		concerns to prevent potential environmental safety hazards.			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		09G127		B. WING _	<del></del>	10/12/2007		
NAME OF P	ROVIDER OR SUPPLIER	000121	STREET ADD	DRESS, CITY, STATE, ZIP CODE				
MY OWN				ACOSTIA AVE, NE GTON, DC 20019				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETÉ DATÉ	
I 095	Continued From page 4  2. The caustic agents storage cabinet with a variety of items was observed unlocked.		1 095	1-2. All caustic agents have been placed in a locked cabinet out of direct reach of the clients. Staff will be re-trained on the storage procedures for cleaning agents. Residence Manager will conduct a weekly environmental audit to ensure		,		
l 135	Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift.		. I <b>135</b>	compliance with caustic agent sto procedures. QMRP will review a environmental audits and provide oversight as necessary to ensure compliance with environmental s precautions.	orage ll			
	This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that each shift conducted a fire drill 4 times a year.			Cross reference response to federa deficiency report citation W440.	d.	10/12/07		
	The finding include See Federal Deficie	ency Report Citation	W440					
1 189	3508.7 ADMINISTI	RATIVE SUPPORT		J 189			'	
	Each GHMRP shal funds received ar	l maintain records of nd disbursed.	residents		Cross reference response to federal deficiency report citation W140 #	al 1-3.	11/1/07- Ongoing	
	Based on interview	met as evidenced by and record review the naintained each resid disbursed.	re				-	
	The findings includ	e:		1				
	See Federal Defici	ency Report Citation	W140					
1 203	3509.3 PERSONN	EL POLICIES		I 203				
	Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.		beginning		See response to L203 on page 6/1	13.	ı	
Health Regu	lation Administration					.,		

	MENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER		1		STATE, ZIP CODE		
MY QWN	PLACE		WASHING	ACOSTIA A STON, DC	VE, NE 20019		
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	Based on record re- have on file for reviewall employees annu- The finding includes Review of the perso October 12, 2007 at GHMRP failed to po	met as evidenced by view, the GHMRP farew current job describeration of the conducted to th	iled to iptions for that irrent ct care	1 203	Employees updated Job Description have been placed on file.  QMRP/Residence Management was maintain a list of all employee hirand review Job Descriptions with employees on an annual basis. The Human Resources Assistant will rethe job descriptions with new empupon hire during the first day of orientation. Evidence of the Job Description review will be maintathe employee's personnel records. Personnel records will be audited routinely by the Director of Prograthe Human Resources Assistant to compliance with annual review requirements.	rill e dates ne eview oloyees ined in	11/1/0
	This Statute is not meased on interview a GHMRP failed to ensprior to employment provided evidence of that documented a hoperformed and that the would allow him or he duties.  The findings include:	and record review, the sure that each emploand annually thereal and aphysician's certific ealth inventory had the employee's healther to perform their re	e byee, fter, tation been status quired		Notification of all outstanding heal certificates for all staff and consult have been distributed to all applica employees with a deadline for submof 11/15/07. Director of Operations/Human Resources will maintain a list of the expiration datall health certificates for all employ Staff/consultants will be notified of need to submit a current health cert within 60-days of the current one's expiration.	ants 10/1 ble Ong nission send es for //ees. f the inficate	17/07- going -
P	nterview with the Quarteries with the Quarteries of the Quarteries	alified Mental Retard ew of the GHMRP's	dation				

		FORM APPROVED
PLE CONSTRUCTION	<u>—</u>	(X3) DATE SURVEY COMPLETED
G		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIDENT/FICATION NI			(XZ) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION  G	(X3) DATE S COMPLI - 10/1	URVEY ETED 2/2007	
NAME OF P	ROVIDER OR SUPPLIER	. 1. cq. c	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MY OWN	PLACE	•		ACOSTIA AV STON, DC 2			
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	PM revealed the Gevidence that curre	September 12, 2007 SHMRP failed to provient health certificates staff and nine (9) cor	ide were on	l 206		- 1	
	Each GHMRP shall obtain employment references on each employee and no GHMR shall employ an individual who has a history the following:  (d) Conviction for a sexual offense or violent crime.						
	This Statute is not met as evidenced by: Based on interview and record review, the GHMRP falled to provide evidence that employment references on each employed we free from a history of a violent crime.  The finding includes:  Review of the personnel records on October 1 2007 at 1:00 PM revealed that the GHMRP evidence one criminal background checks whi disclosed that Staff #1 (1) was employed by to agency on October 4, 2006 with a history of a violent crime. Although Staff #1 background check revealed a Felony charge on his record with two counts associated with a violent offenses, this direct care staff was hired by the agency to work with vulnerable clients in this group home setting.		the		Review of the personnel that the referenced employed Felony charge was over for the told. A request for the told expunged from his crimin made by Human Resource been an employee in good his hire date in 2003. The limitations according to I	oyee ( )'s fourteen years have the charge hal has been ses. Mr. has d standing since he statue of OC law is seven	10/12/07- Ongomg
,			MRP cks which red by the rry of a round record nt d by the		years. The agency does a employ individuals who he sexual offense or violent occur within the statute of the agency will continue criminal background checkground	and will not nave a history of crimes which f limitations. to ensure that cks are	-

HRA

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUILOI	NG	(X3) DATE SURVEY COMPLETED	
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4444				.,		
PLACE .	·	WASHING	TON, DC	20019		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	(X5) COMPLETE DATE	
Continued From page 7			1 229		··· ···	
Each training program shall include, but not be limited to, the following:  (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;  This Statute is not met as evidenced by: Based on the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure staff were trained.  The finding includes:  Review of the in-service training records on October 12, 2007, revealed the GHMRP failed to provide training in communication, dental hygiene and assistive technology.  Also See Federal Deficiency Citation W189  3519.1 EMERGENCIES  Each GHMRP shall maintain written policies and procedures which address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death.  This Statute is not met as evidenced by: Based on observation, interview and record review the GHMRP falled to ensure that the staff and nursing personnel followed the agency policies and procedures on emergencies.			1 229	staff training records were on file Administrative office. All staff h received training in communicati dental hygiene and assistive techn Verification of staff training is m on file in the Administrative Offi Directors of Operations and Prowill duplicate the staff training rethat are on file in the Administration office and place copies of the recording training and place copies of the recording training training that are on file in the Administration of the recording training traini	e at the as on, nology. aintained ce. The grams cords ive ords in	11/1/07
			1 370	Cross reference responses to fede deficiency report citations W153 W154.	ral &	11/1/07.
	Continued From pa 3510.5(f) STAFF T Each training programmed to, the follow (f) Specialty areas residents to be sento, behavior managrecreation, total contechnologies; This Statute is not Based on the review for Mentally Retard ensure staff were training include. Review of the in-se October 12, 2007, r provide training in cand assistive technologies; Also See Federal D 3519.1 EMERGENG Each GHMRP shall procedures which a including fire or gen persons, serious illn This Statute is not Based on observating review the GHMRP and nursing persons policies and procedures of the procedures of the procedures of the procedures which a including fire or gen persons, serious illn this Statute is not Based on observating persons policies and procedures and pro	DENTIFICATION NU  09G127  ROVIDER OR SUPPLIER  PLACE  SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL Continued From page 7  3510.5(f) STAFF TRAINING  Each training program shall include, but limited to, the following:  (f) Specialty areas related to the GHMR residents to be served including, but not to, behavior management, sexuality, nutrecreation, total communications, and attechnologies;  This Statute is not met as evidenced by Based on the review of records, the Grofor Mentally Retarded Persons (GHMRF ensure staff were trained.  The finding includes:  Review of the in-service training records October 12, 2007, revealed the GHMRP provide training in communication, dental and assistive technology.  Also See Federal Deficiency Citation Williams	PLACE  SUMMARY STATEMENT OF DEFICIENCES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  3510.5(f) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;  This Statute is not met as evidenced by: Based on the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure staff were trained.  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PLACE  SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  3510.5(f) STAFF TRAINING  Each training program shall include, but not be limited to, the following:  (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies;  This Statute is not met as evidenced by: Based on the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure staff were trained.  The finding includes:  Review of the in-service training records on October 12, 2007, revealed the GHMRP failed to provide training in communication, dental hygiene and assistive technology.  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Description Description Number:  Description Description Description Description Description Description Description Description Number:  Description	DENTIFICATION NUMBER:  09G127  ROUNDER OR SUPPLIER  ### AND ADDRESS, CITY, STATE ZIP CODE  ### ASHINGTON, DC 20019  ### ASHINGTON, DC 20019  ### ASHINGTON, DC 20019  ### ASHINGTON, DC 20019  ### PROMDER'S PLAN OF CORRECTION (EACH DESPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 7  3510.5(f) STAFF TRAINING  #### Each training program shall include, but not be limited to, the following:  (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexually, nutrition, recreation, total communications, and assistive technology:  This Statute is not met as evidenced by:  #### Based on the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure staff were trained.  The finding includes:  Review of the in-service training records on October 12, 2007, revealed the GHMRP failed to ensure staff were trained.  The finding includes:  Review of the in-service training records on October 12, 2007, revealed the GHMRP failed to ensure staff were trained.  The finding includes:  Review of the in-service training records on October 12, 2007, revealed the GHMRP failed to ensure which address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death.  This Statute is not met as evidenced by:  Based on observation, interview and record review the GHMRP failed to ensure that the staff and nursing personnel followed the agency policies and procedures on emergencies.

(X4) ID PREFIX TAG  I 370 C S all I 392 3. P	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa	09G127  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	4141 ANA WASHING FULL	DRESS, CITY, COSTIA AVETON, DC 2		] 10/1.	2/2007
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I 392 3: PED DE LE COMPANIE DE LE CO	·	ne 8		TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(X5) COMPLETE DATE	
P pr n an in pr lin tr D	Continued From page 8 See Federal Deficiency Report Citation W153 and W154			1370			
3996 33 P	See Federal Deficiency Report Citation W153			1 392	Cross reference response to f deficiency report citation W3	ederal 52.	10/17/07- Ongoing
lea)th Regulation		n plan, as determined					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED				
		09G127		B. WING		10/12/2007		
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY.	STATE, ZIP CODE	10/1	212001	
MY OWN PLACE 4141 ANA			ACOSTIA AI STON. DC	YE, NE				
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1 396	necessary by the in professional service limited to, those ser trained, qualified, an District of Columbia disciplines or areas (f) Occupational T This Statute is not	terdisciplinary team. es may include, but r vices provided by include as required licensed as required for services: herapy; met as evidenced by and record review the surrent forms.	not be dividuals red by	1 396	The current license for the Occup Therapy Consultant has been obta and filed in the applicable person record. Program Director/Human Resources will ensure that profess licenses are up to date and maintafile Director of Operations/Human Re will send maintain a list of the exp dates for all consultant professionalicenses. Consultants will be notif the need to submit a current licens within 30-days of the current one's expiration.	sional sional ined on sources piration al	10/22/07- Ongoing	
1399	that the Occupation license on file at the 3520.2(i) PROFESS PROVISIONS  Each GHMRP shall professional staff to necessary professio accordance with the Individual habilitation necessary by the interprofessional services limited to, those sentrained, qualified, ar District of Columbia disciplines or areas  (i) Speech and language of the sentrained of th	have available qualicarry out and monitonal interventions, in a goals and objective in plan, as determine terdisciplinary team. It is may include, but in vices provided by include in the following of services:  guage therapy; and  met as evidenced by and record review of nal records the GHM	ENERAL fied for s of every d to be The of be fividuals ed by the	1 399	See response to L399 on next pag	e 11/13.	-	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C (DENTIFICATION NUMB		ERVÇLIA MBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
<del>,</del> _		09G127		B. WING	·	10/12/20	107	
NAME OF P	ROVIDER OR SUPPLIER		STREET AC	DRESS, CITY	STATE, ZIP CODE	1 IOI IZIZO	<u> </u>	
MY OWN			WASHING	NACOSTIA AVE, NE NGTON, DC 20019				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	UIDEE J. CA	(XS) OMPLETE DATE	
1 399	on file in the facility.		<del>!! =</del>	1 399	The current license for the Speecl Language Pathologist Consultant been obtained and filed in the per	has 10/	/22/07- igoing	
l 401	of the personnel file PM failed to eviden Therapist has a cur	es:  Residence Director an es on October 12, 200 nce that the Speech L rrent license on file.  ON SERVICES: GEN	07 at 1:50 anguage	· [ 401	record. Director of Operations/Hu Resources will send maintain a lis expiration dates for all consultant professional licenses. Consultant notified of the need to submit a cu license within 30-days of the curre one's expiration.	oman st of the s will be		
	Professional service and evaluation, includevelopmental leve services, and service deterioration or furtiresident.  This Statute is not Based on interview GHMRP failed to p treatment services:	es shall include both a luding identification of all luding identification of all luding identification of the loss of function by and record review the rovided diagnosis, event necessary follow leterioration or further	fent ent y the ; e e valuation,		Cross reference responses to feder deficiency report citations W322, and W352.	al W331		
	functioning for each The findings include	resident in the facility	<b>y</b> -			-	-	
] '	3520.4 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include an annual			l 402	-			
	health inventory of e This Statute is not n	each resident. Thet as evidenced by: and record review the			See responses to L402 on the next p 12/13.	age		

PRINTED: 10/25/2007 FORM APPROVED

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XZ) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		09G127		B. WING		10/12/2007			
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	DDRESS, CITY, STATE. ZIP CODE					
MY OWN	PLACE			IACOSTIA AVE, NE IGTON, DC 20019					
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1 402	Continued From page 11			I 402			•		
	GHMRP failed to provide a annual physical evaluation for one of two residents in the sample.				Cross reference response to feder deficiency citation W322.	al	11/1/07.		
	The findings includ	e:		ļ		,			
	See Federal Defici	ency Report Citation	W322						
1 470	3522.1 MEDICATIO	ONS		1470					
	Drugs shall be administered as set forth in the User Of Trained Employees to Administer Medications to Persons of Mental Retardation or Other Developmental Disabilities Act of 1994, D.C. Code, sec. 21-1201 et seq.				Cross reference responses to fed deficiency report citation W104, W352.	eral , W189 &	10/17/07- Ongoing		
·	Based on observat review, the GHMR Employee failed to	met as evidenced by tion, Interview and re P Trained Medication implement the agen r administering each n.	cord 1 cy policies						
	The findings includ	les:		'					
	See Federal Defici W189, and W352	iency Report Citation	W104,				-		
1 474	74 3522.5 MEDICATIONS			1 474					
		ll maintain an individ stration record for ea			Cross reference response to fed deficiency report citations W33 W365 and W382.		10/17/07- Ongoing		
	Based on observa- review, the GHMR	t met as evidenced b tion, interview and re P's nursing staff faile administration recor ation error.	cord ed to		-				
Hardin Basis	lalien Administration			L	<del>!</del>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER  (X1) PROVIDER/SUPPLIER/			A. BUILDI		(X3) DATE S	EURVEY ETED	
		09G127		B. WING_		10/1	2/2007
NAME OF P	PROVIDER OR SUPPLIER	_			STATE, ZIP CODE		
MY OWN	MY OWN PLACE 4141 ANA WASHING			ACOSTIA AN STON, DC 2	/E, NE 20019		_
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD AF	(XS) COMPLETE DATE
1 474	Continued From page 12			1 474			
	The finding includes Refer to Federal De , W365 and W382.	s: eficiency Report W3:	31, W352		See responses to L474 on previ	ous page	ļ.
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dealth Recuta	tion Administration						